



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PRIME IMAGING PARTNERS LLC
9603 WHITE ROCK TRAIL #110
DALLAS TX 75238

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

EMPLOYERS ASSURANCE CO

Carrier's Austin Representative Box

Box Number 34

MFDR Tracking Number

M4-10-2094-01

MFDR Date Received

DECEMBER 11, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: A position summary was not submitted with the request for medical fee dispute resolution.

Amount in Dispute: \$3,629.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Employers Assurance stands by the original audit of the services in dispute..."

Response Submitted by: Employers, PO Box 71088, Charlotte, NC 28272

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|------------------|--|-------------------|------------|
| June 4, 2009 | Lumbar Epidural Steroid Injection with Epidurogram | \$3,629.00 | \$0.00 |

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits:

- W1 – Workers' Compensation State Fee Schedule Adjustment. Fee Guideline MAR Reduction.
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- A2 – Contractual Adjustment – Any reduction is in accordance with the Focus/Aetna Worker's Comp Access LLC contract.

- 217 – Based on payer reasonable and customary fees. No maximum allowance defined by legislated fee arrangement. Reimb made based on insurance carrier fair and reasonable reimb methodology.
- 198 – Payment denied/reduced for exceeded precertification/authorization.
- 50 – These are non-covered services because this is not deemed a ‘Medical Necessity’ by the payer. Payment denied as not reimbursable per DWC or Medicare.
- 18 – Duplicate claim/service. Duplicate charges.
- 193 – Original payment decision is being maintained. This claim was process properly the first time.

Issues

1. Did the requestor submit the original bills in accordance with 28 Texas Administrative Code §133.307?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(e)(1), effective May 25, 2008, 33 Texas Register 3954, applicable to requests filed on or after May 25, 2008, states in part, "The Division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the Division no later than 14 days after receipt of this request. If the Division does not receive the requested additional information within 14 days after receipt of the request, then the Division may base its decision on the information available..." The Division requested copies of the original bill(s) and explanation of benefits from the carrier on December 20, 2010; the insurance complied and submitted the requested documentation.
28 Texas Administrative Code §133.307(c)(2)(A), effective May 25, 2008, 33 Texas Register 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include "a copy of all medical bill(s)... as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration..."
2. Review of the documentation submitted by the respondent finds that the requestor has not provided a copy of the medical bill(s) as originally submitted to the carrier and/or as submitted for reconsideration. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(A).

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

April 10, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.